THE OUTCOMES OF PARTNERSHIPS WITH MENTAL HEALTH SERVICE USERS IN INTERPROFESSIONAL EDUCATION

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THE OUTCOMES OF PARTNERSHIPS WITH MENTAL HEALTH SERVICE USERS IN INTERPROFESSIONAL EDUCATION: A CASE STUDY

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Abstract

This paper reports findings from a five-year evaluation of a post-qualifying programme in community mental health in England which made a sustained attempt to develop partnerships with service users. Users were involved in the commissioning of the programme and its evaluation, as trainers and as course members. The evaluation employed mixed methods to assess: learners' reactions to user-trainers and users as course members; changes in knowledge, attitudes and skills; and changes in individual and organisational practice. Data were collected from participant observation of training, 13 individual and 18 group interviews with students and their managers (n = 13), and student ratings of knowledge and skills at the beginning and end of the programme (n = 49). The quality of care provided by students was rated by service users (n= 120) with whom they worked, using a user-defined questionnaire. The quality of care, and mental health and quality of life outcomes were compared to those for two comparator groups (n = 44) in areas where no training had taken place.

In general, the students reported positive learning outcomes associated with the partnership orientation of the programme and learning directly from and with service users. A higher proportion of programme users reported good user-centred assessment and care planning and showed greater improvement in life skills compared to the comparators.

This case study provides evidence of the value of partnership working with service users in interprofessional post qualifying education in mental health. The

success is attributed to the design of the programme and the responsiveness of the programme board, which included service users. It may provide a useful model for programmes elsewhere and for other user groups. The case study itself provides a possible model for the systematic evaluation of partnerships with users in education and training.

294 words

Introduction

It has long been the ambition In England of policy makers, service providers and mental health professionals, as well as service users themselves, to establish effective joint working with people who use services (Department of Health, 1998). Although much progress has been made since the days of consulting mental health service users about decisions that had already been made, this work is still challenging. Many suggestions of how it can be done have been put forward (e.g. Crepaz-Keay, et al. 1997; NIMHE, 2003) but these tend to concentrate on the processes of involving service users and provide only anecdotal accounts of benefits to those involved; research on the outcomes of partnership education with service users is uncommon.

Taylor and La Riche's (2006, this issue) review of partnerships with users in social work education identified some evidence from the USA (Scheyett and Diehl 2004) that 'structured dialogue' with mental health users improved students' attitudes but that study did not investigate whether these improved attitudes were followed by changes in practice.

Also in the US, Cook *et al*. (1995) reported the evaluation of a two-day programme to deliver the basic concepts and techniques involved in delivering community development services to mental health professionals in the USA. They used a before and after design to assess the trainees' attitudes towards people with mental illness in the roles of service recipient, service deliverer and trainer. Trainees received the same training on the first day, delivered by someone who was not a user of mental health services. On the second day the 57 trainees were randomly assigned to receive training from either a service user or a trainer who did not have direct experience of using mental health services. Trainees

completed an attitude measure before the first day of training and again at the end of the programme. The authors reported that compared to those who had been trained by a non-user, those who were trained by the user trainer expressed more positive attitudes towards people with mental illness overall, as service providers and trainers, following the training. Of course, the positive change in attitudes reported could be due to the trainees having a different trainer on the second day of the programme. Alternatively, it could be due to some other personal characteristic of the trainer, as opposed to their status simply as a user of mental health services. Consequently, the generalisations that can be drawn from the study are limited and once again, there is no evidence of any impact on practice.

Partnerships in interprofessional education

It is particularly interesting to examine partnerships with mental health service users in an interprofessional context. Interprofessional working challenges the power structures between professions, aiming to break down professional hierarchies. In the same way, service user participation challenges the traditional power structure between professional and patient/client. The greatest differential is often perceived to be between doctor and patient (e.g. Crawford et al. 2003) but in mental health care, where a range of professionals can have the power to administer compulsory care and treatment, there can be very complex issues to overcome if partnership working with service users is to be achieved. This is further complicated by the judgement of patients being called into question on account of their illness (Rose et al, 2003).

In interprofessional education, especially in the context of university education, similar issues of power have to be overcome to achieve both partnership working

between the separate departments which provide professional training and the inclusion of service users. Equally important is the contribution service users bring to education, not only their perspective but also a knowledge base which is of immediate relevance to practice (Levin, 2004; Tew et al. 2004). However, service user input can bring a further challenge; professionals tend to be most comfortable with the concept of propositional knowledge, defined as discipline-based concepts, generalisation and practice principles that can be applied in professional action (Taylor, 1997, Chapter 11). Service users trainers, on the other hand, are generally brought in to provide experiential knowledge by giving 'testimony', telling their personal stories and experience. Training based on personal history and insight is relatively new and can be stressful for the trainer and the learner (e.g. Daykin et al, 2002; Turner et al, 2000). Therefore, both have to be supported and guidance on how this can be done is emerging (e.g. Levin, 2004; Tew et al. 2004). However, we could find no structured evaluations of the outcomes of this practice.

The Birmingham University Programme in Community Mental Health

This paper updates a case study of partnerships with service users in a postqualifying interprofessional training programme in community mental health. As previously described (Barnes et al., 2000), the perspectives of mental health service users were represented in the commissioning, management, delivery, participation and evaluation of the programme. In this paper we report a structured evaluation of the outcomes. Taking each role undertaken by service users in the programme in turn we describe the contribution made by users and the interim outcomes for the service users, the students and the programme. We then look longer term at the influence this partnership had on the students'

learning and the changes observed in their attitudes to working in partnership with users, their skills and their practice. Finally, we report the outcomes for users with whom the students worked.

The programme of interprofessional education was a two-year part-time, post-qualifying course for mental health professionals that required one day a week attendance at the university during term-time and further study and practice in the workplace. The two-year programme led to a postgraduate diploma. It focused on working with people with severe mental illness living in the community. Its stated aims were: 1) to train staff in the use of evidence-based psychosocial interventions (cognitive behaviour therapy and family therapy); 2) to improve understanding of, and skills in, interprofessional working; and 3) to increase awareness of the importance of working from a service user's perspective. Central to the programme was a strong value base which emphasised partnership working between service users and professionals in the development of user-centred care. The programme was interprofessional in management, staffing and student intake. The core professions involved were mental health nursing, social work and occupational therapy, with a small number of psychologists and psychiatrists. A profile of the participants is given in Carpenter et al. (2006).

Methods

The programme was evaluated over five years by the authors, an external research team from another university. The evaluation was formative as well as summative: emerging findings were fed back to the programme director and the programme management board and contributed to course development. The evaluation was approved by a NHS Multi-Centre Research Ethics Committee. The data reported in this paper derive from:

(1) Participation in meetings of the programme management board and informal discussions with their members.

(2) Participant observation of teaching; the observer (CD) made herself known to students and worked with them in small groups/pairs as appropriate. The focus of the observations was on the reactions of the students to the content and delivery of the teaching, interprofessional interactions, stereotypes and the voicing of attitudes to service users.

(3) three group interviews with three cohorts of students at the end of the first and second years of the programme. The 18 groups were facilitated by members of the external evaluation team and discussion concentrated on three primary goals of the programme as above.

(4) A self-report questionnaire. We based this 'core competency' measure on the capability framework for mental health practitioners (Sainsbury Centre for Mental Health, 2001 p8) in order to assess changes in students' perceptions of their knowledge and skills. Using a 10-point rating scale, they were asked to rate the importance of each of the core competencies and to assess their own levels of skill and knowledge at the beginning (T1) and end of the taught programme (T2). Three items concerned partnership working with service users and are reported here.

(5) individual workplace interviews with 23 students in 13 teams. A semi-structured interview was used which enquired into student's motivation for seeking access to the programme, their reactions to the training, the skills and knowledge they felt they gained and issues arising from trying to implement learning.

(6) individual interviews with the 13 team managers or clinical supervisors of the students, designed to corroborate the students' accounts of the implementation of their learning.

(7) users' opinions of user-defined quality of care outcomes. For this we used a 16-item, 5-point rating scale especially designed for this evaluation (Barnes et al., 2000a). This assessed what users considered to be important outcomes of postqualifying education, such as: the user's professional relationship with the trainee; the extent to which the user felt involved in their own care and treatment; the quality of the information and advice given; and whether they worked effectively with other agencies. Users were offered the choice of not participating, participating by returning the questionnaire anonymously by post, a telephone interview, being interviewed personally by a trained user-researcher or by a member of the evaluation team. Equivalent data were collected from service users in two districts in another part of the country where no equivalent training had taken place.

(8) Assessment, using standardised measures, of mental health, social functioning and quality of life outcomes over six months. There were compared to outcomes for users in the comparator districts. Details of this component of the evaluation, including the characteristics of students and comparator staff and of both groups of service user participants are given in Carpenter et al., (2006).

(9) Frequent discussions with the programme director and deputy director. In addition, the programme director was invited to respond in writing to issues raised in the evaluation report.

Data Analysis

Notes of participant observations and quotes from group and individual interviews were made at the time on either flip chart paper (for group interviews) or on the semi-structured interview schedules. These were entered into computer software package NVIVO and analysed thematically (Searle, 2000). The first level of analysis was the roles in which service users were involved with the programme, i.e. in commissioning, programme management, teaching and learning. Because the study was concerned with the achievement of educational outcomes, the second level analytical framework employed the well-known Kirkpatrick (1967) model, as developed by Barr et al. (1999) for the assessment of outcomes in IPE. Relevant components of this framework were: learners' reactions; knowledge and skills in partnership with users; modifications of attitudes to service users; transfer of learning to the workplace (behaviour); changes in organisational practice; and outcomes for service users.

In respect of these outcomes, observations and responses were categorised as positive/negative and explanations were classified. Quotations were selected to represent the various positions expressed by the respondents or evident in the observations. Where the programme responded to a particular set of findings with a change to its content or structure, this is explained.

Quantitative data were analysed using SPSS 12. Changes in students' self-rating of knowledge and skills were assessed using the paired-sample t-test. Quality of care ratings were categorised as positive or negative and analysed using chi-square or, when cell counts were less than five, Fisher's exact test. Clinical, social

and quality of life outcomes were evaluated using analysis of covariance, with baseline scores as a covariate.

Findings

Analysis of the interview data showed that there were not obvious differences between the views expressed by students from the different professions on the programme. This is consistent with previously reported findings concerning their attitudes to the principles of community care (Barnes et al., 2000b). Consequently, findings are presented from the students as a whole, or ascribed to individuals. There were some differences between students from the four different cohorts studied and these are noted below.

Service users in commissioning

The commitment to partnership with service users was established in the original specification for the programme and reinforced by service users participating in the commissioning of both the programme and the external evaluation. This process has been reported previously (Barnes et al. 2000a) but the impact continued to be felt throughout the five- year evaluation. In particular, service users took an active part in the Steering Group which advised the research. A major influence exerted by them was ensuring that all discussions were in accessible language, the research methodology was adequately explained and outcome measures were carefully scrutinised for their suitability and the possible impact on service users. The service users on the Steering Group were amongst its longest serving members.

Service users in programme management and teaching

Service users participated in the Programme Management Board representing the views of people with severe and enduring mental health problems. They were involved in the selection and recruitment of new staff, contributed to curriculum development and helped with assessment.

Service users' most influential role was in teaching: at first they were brought in to teach on a sessional basis on two modules: the foundation module and the 'user participation and self help' module[1]. However, once the programme had been running for two years and sufficient money was available, the university appointed two service users to the staff team as part-time lecturers. These lecturers convened the user participation module and contributed a user perspective on other modules, such as assessment and care planning. They also provided support to service users contributing to, and participating in the programme as students.

Learners' reactions

Reaction to service users as trainers was mixed. Many students valued hearing firsthand experiences of mental illness and of the use of services. They respected service users for being willing to tell their stories:

> *There is a shift in balance when users come in – it felt like they were really teaching us something. (Group interview 11)*

For some students, service user trainers made an appreciable difference and offered an alternative to the teaching offered by professionals:

[1] A description of this module and its assessment by service users is given by Bailey (2005).

I felt it was good to have service users teaching on the course. There was one session on risk and I realised that I had never thought of it from a service user perspective before. (social worker 5)

Their teaching felt relevant to students who were able to see its wider application:

The people on the user module were good. It was also new. It had such an impact because I knew I was going to use it. (CPN 2)

However, some students felt that they could not criticise service users' views in the way they might challenge professionals, and they were afraid to ask questions fearing that they might say the 'wrong thing'. Students were also critical of the teaching skills of some service users:

I think it is very positive to have service users as presenters but in fairness some need more support in presenting. Just having the status of service user does not qualify you to stand in front of a group of professionals. However, the positive aspects need to be weighed up with the quality of what is said - there are only so many times that you can hear how poor services are. (OT 7)

Participant observation indicated that service user trainers were not always given the respect of other lecturers, and this was commented on by students.

Service users certainly did not get the same sort of respect as others teaching on the course, I don't know what it was but maybe it was because they weren't qualified or maybe some of the presentations I saw were a bit woolly and you weren't really sure where it was going. Maybe in order to present as tutors or trainers, whatever, service users need more input from

people with very good presentation skills, because, if you put me in front of a class I wouldn't function well. (CPN 8)

Consequently, the programme ran workshops to train service users in presentation skills so that they could use their lived experience of mental health services more effectively. An annual development day was held to discuss students' feedback with service user presenters. A group (Suresearch) was set up at the university run by and for service users to provide support for any users who were contributing to the programme or involved in research locally. The programme also introduced joint teaching sessions in which a service user trainer was paired with an experienced staff member. This ensured greater consistency in the delivery of the teaching and modelled partnership working. It also addressed some of the anxieties students felt in challenging the views service user trainers were putting forward. The immediate outcome was improved ratings of teaching by service user trainers, while the longer-term impact of how this learning was put into practice is discussed below.

Service users as students

Although originally set up to train mental health professionals, the Programme Management Board resolved that it would be consistent with the user-centred value base of the programme for service users themselves to be enrolled as students if they met the academic entry criteria. These students were nominated and sponsored by the local health trusts and recruited on the basis of their involvement as 'user consultants' on trust committees or as user development workers in community mental health teams. It was argued that educating users to a similar level as professional staff would enhance partnership in practice. In each cohort one or two service users identified themselves and in one year six

service users were recruited. Of course, some of the professionals on the programme are likely to have had direct experience of using services themselves.

There were mixed reactions from other students to finding that the student group included identified service users. Reactions ranged from welcome to shock:

> *I do not have a problem with service users on the course. I think it is helpful to have them there. I see them as people. It helps to remind us we are all people in this mental health venture together.* (OT 16)

> *Initially I was shocked that users were on the course. It was not just that there was the user; it was the way it was managed.* (CPN 2)

As with service user trainers, some students stated that they experienced difficulty in debating issues freely in front of identified service users. They believed that they should be able to overcome this reaction but were nevertheless felt inhibited:

> *I have some reservations about service users as students because it limits how comfortable we are talking about some things. It makes me more conscious about what I say. I would also be unsure how to have a debate with someone - if I upset them, then I will feel guilty.* (CPN 18)

> *Individually service users can be critical and quite aggressive; therefore the rest of us all shut up. You could argue that we should get past that but there is something about an argument with a service user that makes it unequal. I would not feel the same about an argument with other members of a multidisciplinary team. There are lots of things not said.* (OT 7)

Students found it especially difficult when there was only one service user in a cohort.

I found this really problematic. I would find it easier to disagree if there was more than one person. I would have felt like I was singling him out if I had disagreed with him. (OT 7)

There was not only an issue of attitude; there were also practical difficulties. For example, problems arose when service users became unwell. Students felt the programme staff had been unprepared for this situation and were slow to handle it:

There has been one service user who is a student on the course who has not been well. She was just anti everything and it can get your back up when you hear everything being negative. I think she slowed us down a lot. (CPN 17)

Another source of tension was that students were expected to applying their learning of skills in clinical practice. Service users were unable to participate fully in the programme in this way and different assignments had to be developed. The programme staff responded by making clear its rationale for training service users:

The programme has never aspired to train users to become quasi professionals. Instead it has sought to give users an opportunity to question the appropriateness of contemporary approaches and incorporate this widened understanding in their role with other users and colleagues. (Programme Director)

The programme also increased the size of the service user group on modules where partnership with users was a focus. This was done by inviting professional students to bring a service user with whom they worked to the module and recruiting other service users to attend the module as paid participants. The

presence of a larger proportion of service users in the module enabled more open discussion.

Over the 5 years of the evaluation, considerable change was observed on the programme and in its impact in the region. The commitment to service user partnership remained strong and service user-taught modules became less controversial as the teaching became more effective. However, service users on the staff team who moved on to advance their careers were not replaced, apparently because of reduced funding. Also, none of the service user students who were tracked through the programme qualified successfully at the end of the two years, in most cases because they failed to submit the course assignments and/or dropped out because of mental ill health.

Changes in knowledge and skills

The core competences rating scale was completed on two occasions by 49 students drawn from two intakes of the course (response rate 76% of those who completed the two years). At the beginning of the programme, almost all students rated knowledge of service user involvement and empowerment as “extremely important” (Table 1). At the beginning of the Programme, students rated their knowledge and skills in ‘facilitating therapeutic co-operation’ and in using a ‘user and carer oriented perspective based on partnership in the provision of assessment, treatment and continuing care’ as modest (mean ratings around 6 on the 10-point scale), although the standard deviations were quite large, indicating a wide range of ratings from the students. But they reported the knowledge gained about working from a user and family perspective led them to review their own practice.

Table 1 about here

At the end of the end of the Programme, ratings were substantially higher (means score over 8), with a much smaller range of response (fig. 1).

Students explored empowerment, considering when and how service users should be involved in the planning, management and review of services and how they should participate in planning their own care. It was accepted that empowerment was challenging:

> *The need for balance between user empowerment and boundary setting; the case-study … was thought provoking!* (CPN 12)

It was also suggested that service users in general had changed in their demands:

> *Users seemed to have changed stance, in terms of fighting the system; now they are collaborating to change it.* (SW 5)

More practical knowledge reported included learning where and how to access information, developing directories of local service user groups/resources and understanding the value of advocacy.

Changes in attitudes

In the workplace interviews, students reported changes in attitudes towards partnership with service users, e.g.:

> *I'd say the biggest thing the course has given me is the user perspective. I turned up thinking, 'Yeh, yeh. It is not the real world'. Now I think it can be part of the real world. (Group Interview 12)*

This was the area of teaching from which students felt that they had benefited most:

> *[the programme] has not really changed the way I work with other professionals but it definitely has with service users. Before I was only the nurse and they were the service user. Now they are no longer just the illness. It was the best thing I got from the course. Previously I was anti- the user movement. I thought it was just another movement. But when* [user presenter] *was talking I was thinking, 'Oh, I've done that'. (CPN 26)*

Changes in behaviour: individual practice

The interviews with students revealed a number of ways in which they had changed their practice as a result of their learning. Awareness of the imbalance of power between service users and professionals had made students more conscious of sharing decision-making and a need-led approach:

> *Person centred planning has had an impact. Seeing things from a user's point of view can be liberating rather than restricting. For example, what one service user really wanted was to see her grandchild - and she did not have to have a day centre place to do this.* (Group interview 15)

Many students considered that changes in their practice had been subtle rather than fundamental but these changes could have a beneficial effect for service users, for example, giving them more time and being more open to considering risk:

> *My practice has not changed radically due to the Programme in the way I work with users - although I probably make more time for them. I keep my*

caseload low and respond quicker. I go when they need me, they don't ask for help often. (CPN 1)

I do not think that the course has changed the way I work with service users but I am more adventurous and take risks. I am not afraid of upsetting clients. I back it up with knowledge and information. (CPN 18)

Students experimented with obtaining feedback about the services they received; this met with varied success. Managers reported that many team colleagues were not confident about this work and welcomed the new skills that students brought back to their teams from the programme.

Change in behaviour: organisational practice

Changes in partnership practice with service users introduced by the students to the workplace included the setting up and running service user groups, ensuring user views were fed into service planning decisions, supporting service users on staff recruitment panels, writing leaflets for users and carers about the services offered and collating information about resources for users

The barriers to implementing this learning were more often about resources than attitudes, but concerns were expressed about tokenism and representation. There was also some evidence of the changing climate of partnerships with service users over the five years of the study. At the start of the evaluation, students were reporting setting up user groups or supporting fledgling groups. By cohort 4, user groups had been set up in most trusts and users were exerting a much wider influence; the students' roles became more supportive.

Outcomes for users as service recipients

Overall, responses to the user-defined questionnaire were positive (Table 2). Almost all users believed that the students treated them with respect and understood them and their experience of mental ill health. With regard to multi-disciplinary working, around three-quarters of users considered that the student had worked with other agencies to ensure their needs were met. Likewise, very similar proportions reported that their named worker checked that they had been able to get the help the user considered that they needed from services. However, users in the comparator groups reported similarly positive opinions.

Table 2 about here

Over three quarters of users in the study groups stated that the students had had involved them in care planning as much as they wished; this compares favourably with users in the comparator groups. Similarly, significantly greater proportions of users reported that the students had asked whether they wanted a carer or member of their family involved in planning their care. This could not be accounted for by a greater proportion of users in one group living at home because proportions were similar. It may therefore be attributed to the programme's teaching emphasis on involving family carers in care planning and on family therapy.

The service users with whom the students worked (n=72) improved significantly over six months in terms of their social functioning ($F_{1,62} = 4.12$, $p = 0.047$) and life satisfaction ($F_{1,59} = 6.43$, $p = 0.014$), but not in their mental health status. Users in the comparator groups also improved in life satisfaction and social functioning, but the improvement in social functioning was significantly greater for those users in the programme group than for the comparators ($F_{3,155} = 7.31$ $p < 0.001$). These results are reported in detail in Carpenter et al. (2006).

Discussion

In this case study, partnership working that was both modelled by, and taught on, the programme was challenging for programme staff, the students and the service users involved. Much of the experience was positive but difficulties were encountered. It would not be appropriate to generalise these conclusions, but the lessons learned are likely to be relevant for programmes elsewhere.

Thus, it was important that the commitment to partnership working, including working in partnership with service users was evident from the start. This was built into commissioning, programme management, delivery, and evaluation. It was made explicit in programme objectives and learning outcomes.

Partnership working which pushes at the orthodox structures of power is acknowledged to be difficult. In modelling partnership working with interprofessional partners tensions were experienced when the imbalance of power between stakeholders was too great or when the conventional order was challenged. In these situations, the programme did not back off but sought solutions which would help to equalise partnerships. For example, when students expressed concern that their learning was being affected by variable standards of teaching by service users, the programme responded by obtaining funds to train the user-trainers to use their experiential knowledge more effectively. When professionals expressed discomfort learning alongside service users, the programme challenged professionals' attitudes by increasing the number of service users involved. This reduced their minority status in the student group and prevented service users being seen as vulnerable to challenge.

The constant reminder of the programme's partnership aims in the make-up of the management board, the staff team, the student body and the programme content meant partnership working was integrated into the student's experience throughout their learning. There was no escaping the issues and even when unfortunate incidents arose, such as a service user student becoming unwell, accommodation was found, as it has to in practice. The experience of this partnership in action, together with enhanced skills and knowledge, seems to have given students the confidence to implement this learning, affecting not only their personal practice but also influencing change in their agencies.

Of course the programme did not operate in a vacuum; it must be put in context. As it was a post-qualifying programme, the professionals on it were already in practice and often had had many years of experience. As an experienced practitioner it is not easy to acknowledge that you may not have been putting service users first in the interventions provided. It often took an anecdote or personal story from a service user on their experience of receiving care for students to appreciate the changes in attitudes needed and it is to the credit of students that they were willing to subject their practice to this level of reflection. As it was a voluntary programme perhaps it attracted students who were particularly open to change but overall, the teaching from service users contained some of the strongest messages that students apparently took from the programme overall.

However, students were not only subject to learning from the programme but also received daily influence from their workplace which could often act as a barrier to

implementing learning. The responsibility on students to share their learning with their colleagues was generally regarded as a burden and rejected by teams, but engagement with service users tended to be welcomed. Colleagues were often relieved to see students take responsibility for promoting partnership working with users such as collecting feedback, running groups and accessing information. At the same time, students were able to change their personal practice to provide more person-centred care.

Conclusions

The evaluation of this programme provides some evidence of the value partnership working with service users in interprofessional post qualifying training. The students, the majority of whom were experienced professionals, acknowledged the influence of working with and hearing directly from service users. It not only helped to develop ability for working in partnership with users, but with altered attitudes, new skills and a favourable policy context, students found that they could introduce this learning into their personal practice and affect a degree of organisational change.

We cannot say whether the same ends could have been achieved without direct user partnership in the programme. To examine this question would require comparison of outcomes with a programme which taught about partnerships with users rather than involved them directly (c.f. Cook et al., 1995).

The level of success achieved by service user involvement in this training programme must in part be attributed to original design of the programme and the responsiveness of the programme staff and board. If service users are to be empowered in contributing to professional training, they cannot be expected to

simply react to the status quo. Their role is to influence change and those changes are likely to be in the programme as well as through the learning experiences of students. The programme may provide a useful model for programmes elsewhere and for other user groups. Further, this case study provides a possible model for the systematic evaluation of partnerships with users in education and training.

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Table 1: Partnership Working with Users: means and (standard deviations) (N = 49)

Scale: 1=not at all, 5=intermediate, 10=very high/expert.

	Importance T1	**Level of Competence T1**	**Level of Competence T2**	**P (paired t-test)**
Knowledge of factors involved in facilitating therapeutic co-operation.	9.28 (1.35)	5.82 (2.18)	8.33 (1.19)	<0.001
Skills in facilitating therapeutic co-operation.	9.27 (1.38)	5.92 (2.33)	8.21 (1.27)	<0.001
A user and carer oriented perspective based on partnership in the provision of assessment, treatment and continuing care.	9.38 (1.51)	6.03 (2.14)	8.45 (1.2)	<0.001

Figure 1: Partnership working with users: Overall students' ratings of importance, and self-assessments of knowledge and skills at T1 and T2 (N = 49).

Scale: 0=not at all, 5=intermediate, 10=very high/expert.

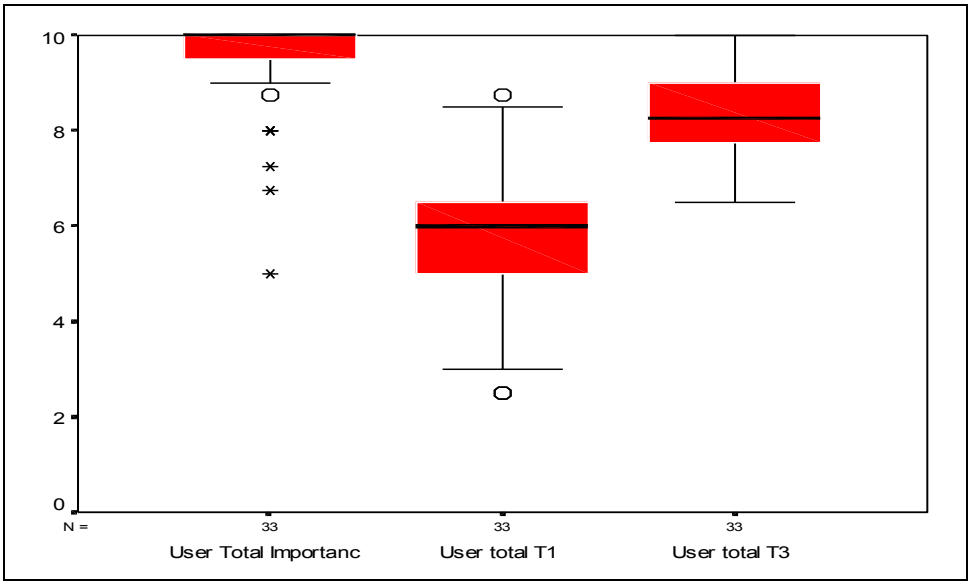

Table 2: Service Users' Quality of Care (User defined outcomes measure, Barnes et al., 2000)

	Positive Response % (response rate)				X^2 or Fisher's
(Named worker = student on the Programme or 'key worker')	**Cohort 3 (n = 60) (80%)**	**Cohort 4 (n = 60) (68%)**	**District 1 (n = 21)**	**District 2 (n =23)**	**P**
1. Do you feel your named worker treats you with respect?	97	93	100	93	>0.1
2. Do you feel that your named worker treats you as an individual rather than as a label?	86	90	90	87	>0.1
3. Do you feel comfortable with your named worker?	95	98	95	91	>0.1
4. Do you feel that your named worker actively listens to you?	95	95	100	95	>0.1
5. Do you feel that your named worker understands you?	87	85	86	84	>0.1
6. Does your named worker respect your experience of mental ill health or distress?	92	86	91	89	>0.1
7. Do you feel that you have been encouraged by your named worker to say what your problems and needs are?	88	92	76	70	0.03*
8. Have you been involved as much as you would have liked in planning your own care and treatment with your named worker?	78	83	64	53	0.02*
9. Has your named worker asked if you want a carer or member of your family involved in planning your care?	50	65	16	26	<0.001***
10. Does your named worker work with other agencies and professionals so that your needs can be met?	81	73	71	68	>0.1
11. If you have involvement with more than one professional worker, have you found that they give you consistent information and advice?	67	69	71	68	>0.1
12. Does your named worker check whether you have been able to get the help you need from services?	72	66	66	66	>0.1
13. Has your named worker been able to answer your questions on medication such as why you are on it and its side effects?	78	84	66	56	<0.01**
14. Does your named worker consider your cultural or religious needs?	54	51	68	58	>0.1
15. Does your named worker always use his/ her power appropriately?	82	81	80	78	>0.1
16. Does your named worker let you take risks?	82	81	80	78	>0.1